Finding the Balance: Public health and social measures in Kenya

This report describes findings from a telephone survey with 1,356 people conducted in September 2021, alongside local epidemiological and secondary data. The survey was approved by Amref Health Africa Ethics and Review Committee to examine experiences and responses to public health and social measures (PHSMs) to prevent COVID-19 transmission. This is the fourth PERC report since the pandemic began (see the first, second and third reports).

What are the highlights from this report?

Situational Awareness

Kenya experienced two successive waves of COVID-19 between March and September 2021. Both peaked at approximately 1,300 new cases per day, though test positivity suggests even more went undetected.

PHSM Support and Self-Reported Adherence

Support for and self-reported adherence to measures restricting social gatherings and movement increased since February 2021, likely reflective of the stricter measures in place at the time of the survey, including a ban on public gatherings and a nightly curfew.

Information and Risk Perception

Since February 2021, there was growth in respondents' perceived risk of infection, belief COVID-19 would greatly affect their country and anxiety about resuming normal activities. Along with the COVID-19 pandemic, access to income and food were top concerns among respondents.

Vaccine Beliefs and Uptake

More than 80% of respondents reported either being vaccinated or planning to get vaccinated for COVID-19, the highest rate in the Eastern region. Among respondents unlikely to receive a COVID-19 vaccine, low risk perception and lack of information were the primary reasons cited, reinforcing the need for continued investment in risk communication using trusted sources.

National COVID-19 Data Snapshot as of 3 October 2021

Vaccination rate Percentage of population with at least one dose of a COVID-19 vaccine	6%
Number of doses in country	5,045,780
Cumulative incidence per 100,000 people	465
Total reported cases	250,114
Total confirmed COVID-19 deaths	5,140

Data source: Africa Centres for Disease Control and Prevention

Secondary Burdens

Fewer households that needed medical attention had to skip or delay care than did in February 2021. The economic impacts of the pandemic continue to affect access to income and food security, with nine in 10 respondents reporting income loss since the beginning of the pandemic, and three-quarters reporting missing a meal in the past week.

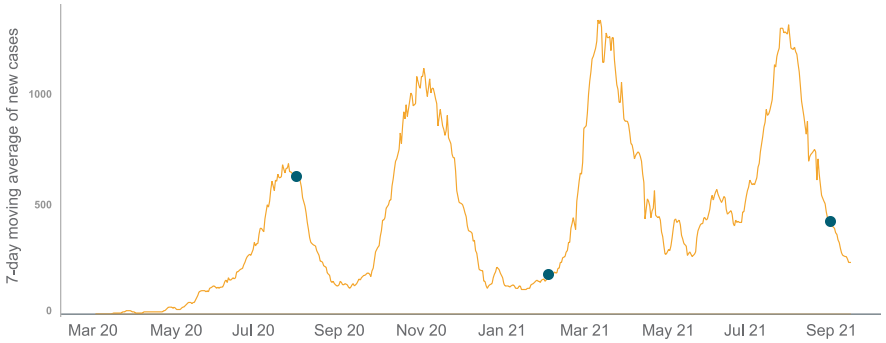
What are the key trends from this survey?

Personal risk perception and support for PHSMs have shifted with the epidemiological situation in Kenya; during periods of low transmission, respondents expressed low risk perception and support, whereas during periods of high transmission, risk perception and support increased.

	Aug 2020	Feb 2021	Sept 2021
Support for staying home	72%	↓ 33%	↑ 45%
Personal risk perception	31%	↓ 22%	↑ 33%
Satisfaction with government reponse	73%	↓ 68%	→ 67%
Vaccinated/likely to get vaccinated	*	59%	↑ 84%
Income loss since pandemic start	77%	↑ 88%	→ 90%

* Vaccines were unavailable at the time of the survey

Changes in percentage of +/- 5% are indicated with an ↑ up or ↓ down arrow



Situational Awareness

What is the situational context influencing COVID-19 response?

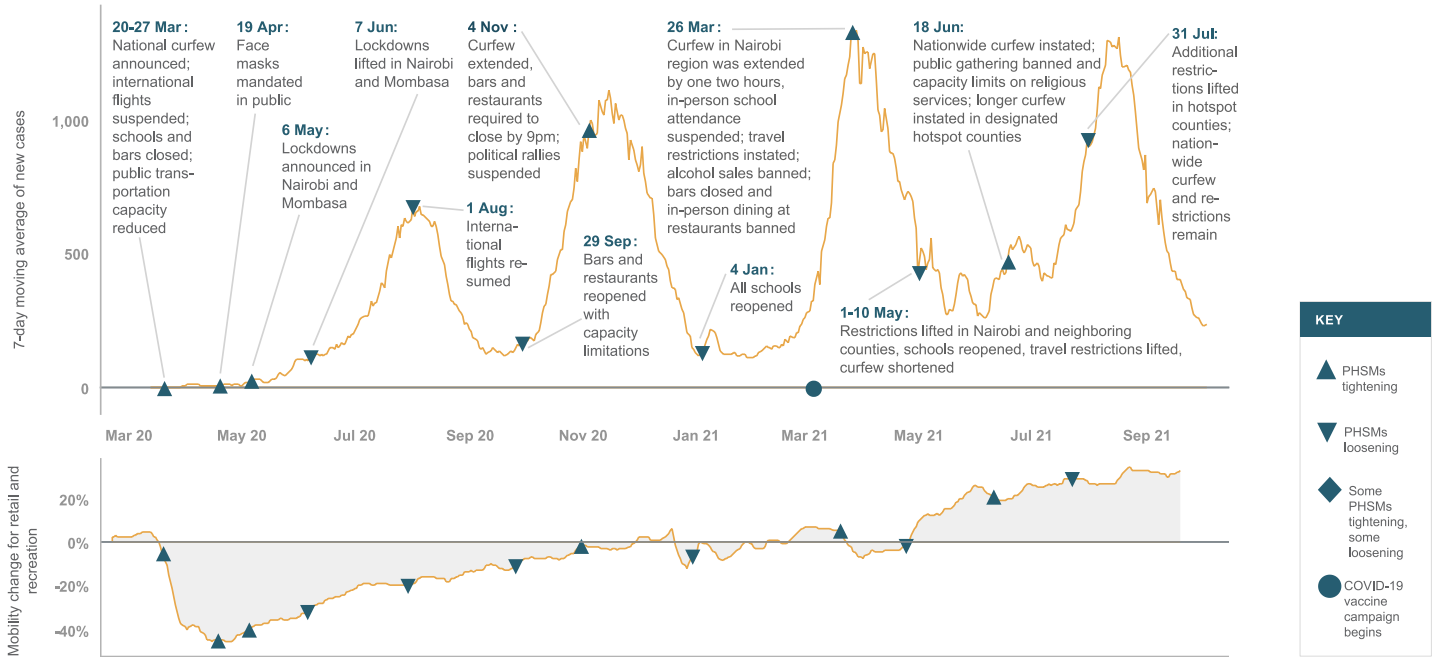
Kenya's third and fourth waves of COVID-19, in March and August 2021 respectively, both peaked at approximately 1,300 new cases per day. The August wave was likely associated with the Delta variant, first reported in the country on 25 May 2021. Test positivity peaked at 17% during both waves, suggesting that cases went undetected or unreported. However, President Uhuru Kenyatta noted in late October 2021, that since March 2020, overall laboratory capacity has improved, as has ICU, hospital and oxygen capacity, due to investments in strengthening the health sector.

Later COVID-19 mitigation measures were less severe than those implemented during the first two waves in 2020. In July 2021, a nationwide curfew, bans on in-person meetings and public gatherings, and capacity limits on religious institutions were instituted; all measures were in place during the fielding of this survey, though the nationwide curfew was lifted on 20 Oct 2021. In order to target response efforts, lockdowns were also imposed in high-incidence cities and districts, and were lifted as the epidemiological situation permitted. Protests against lockdowns and brutal police enforcement of PHSMs have been ongoing since early 2020; they broke out again in July 2021 and later in August, the latter of which was in direct response to alleged extrajudicial killings of people found breaking curfew. Politicians also reportedly used churches as a way to circumvent bans on campaign rallies ahead of the 2022 general elections.

Kenya started vaccinations for COVID-19 in March 2021, initially targeting health workers, security personnel, frontline workers and the elderly. In September 2021, eligibility expanded to people over 18 with underlying medical conditions or disabilities. The government aims to vaccinate the entire adult population (26 million people) by 2022; however, as of 3 Oct, only 6% of the population has been reached. The government is attempting to boost vaccine uptake through various means, including a vaccine mandate for public employees and the loosening of some PHSMs, namely the curfew. The vaccines currently available include AstraZeneca, Sinopharm, Pfizer/BioNTech, Johnson & Johnson and Moderna.

The COVID-19 pandemic is only one of many challenges facing Kenya at present. As a result of climate-change-associated droughts, low agricultural production and rising food (and fuel) prices, about 2 million Kenyans are experiencing high levels of acute food insecurity. Acute food insecurity has increased threefold since 2020, and the situation is projected to deteriorate even more in the coming months.

Varied factors — including circulation of the Delta variant and increased mobility — likely contributed to the March and August waves; strategic deployment of PHSMs appear to have been effective in reducing transmission.



PHSM Support and Self-Reported Adherence

Do people support and follow measures?

What the data say

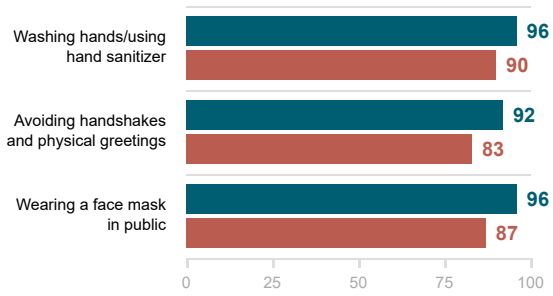
Self-reported adherence to measures restricting social gatherings and movement increased from February 2021 (by 8 and 5 percentage points, respectively), with September findings comparable to Eastern regional averages (34% and 30%). Kenya was one of only two surveyed Member States to see an increase in self-reported PHSM adherence (in addition to Uganda). These findings are likely related to the tightening of some measures between March and October 2021 (including targeted lockdowns, a ban on public gatherings and in-person meetings, capacity restrictions for places of worship and a nightly curfew).

- Personal risk perception was associated with reported adherence: across all PHSMs, respondents with high personal risk perception reported greater levels of adherence than those with low personal risk perception, even for measures associated with economic burden such as those restricting movement (31% vs. 24%).
- While support for individual measures did not change substantially since February 2021, self-reported adherence dropped by 11 percentage points driven by a nine-point drop in mask-wearing; it was the only PHSM category to see a decrease in adherence.

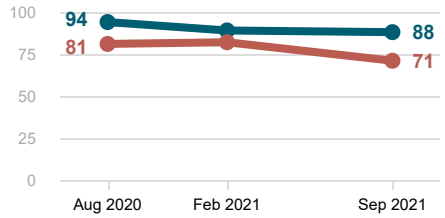
Individual measures

While support for all individual measures was comparable to the Eastern regional average, self-reported adherence was 14 points higher (57%).

Support for and adherence to each individual measure in Sep 2021



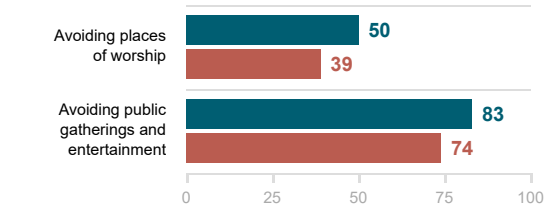
Trend in support for and adherence to all individual measures (composite score)



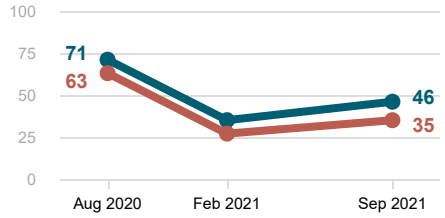
Measures restricting social gatherings

Self-reported adherence to avoiding places of worship increased by 10 percentage points since February 2021, likely a result of new measures restricting capacity at religious institutions.

Support for and adherence to each social measure in Sep 2021



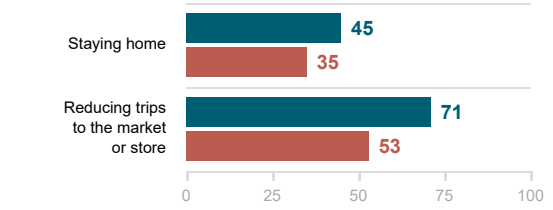
Trend in support for and adherence to all social measures (composite score)



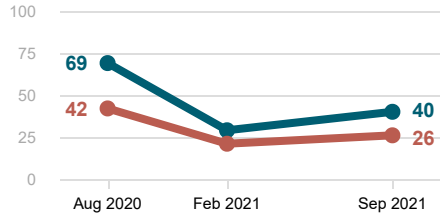
Measures restricting movement

Self-reported adherence to measures restricting movement increased since February 2021, driven by a rise in staying home (of 9 percentage points), likely related to the combination of regional lockdowns, bans on

Support for and adherence to each movement measure in Sep 2021



Trend in support for and adherence to all movement measures (composite score)



Information and Risk Perception

How do people understand risk?

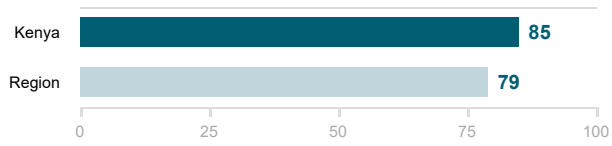
What the data say

Nearly nine in 10 respondents believed that COVID-19 would affect many people in Kenya, and only one-third perceived a high personal risk of infection, both comparable to trends in other surveyed Eastern Member States. Since February 2021, a larger share of respondents reported high perceived risk of infection, belief that COVID-19 would greatly affect their country and anxiety about resuming normal activities; this is potentially due to the two waves of COVID-19 cases in the intervening period.

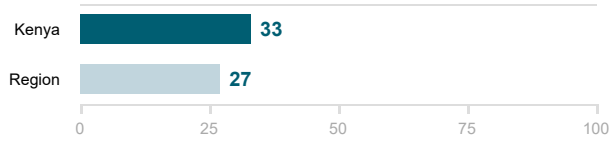
- Income status was associated with perceived risk of infection: a larger share of lower-income respondents reported belief that if infected by the virus, their health would be seriously affected (61% vs. 48% of higher-income respondents). This could reflect the financial barriers many face in accessing quality treatment if infected.
- Vaccine intent was also associated with risk perception; of those reporting high perceived risk of COVID-19 infection, a higher percentage reported being vaccinated or likely to receive a vaccine (35% vs. 22% unlikely to receive the COVID-19 vaccine), suggesting that messaging reinforcing the risk posed by COVID-19 may be an effective strategy to encourage vaccine uptake.
- Unemployment eclipsed COVID-19 as a top concern for respondents by almost 25 points (76% vs. 50%), likely due to widespread pandemic-related lockdowns and the associated loss of income. The Kenyan economy contracted in 2020 — with the lowest GDP in 12 years — and nearly 1 million people lost their jobs. Access to food was also a top concern for more than two in five respondents; income loss and decreasing consumer purchasing power combined with high rates of food insecurity, inflation and poor agricultural harvests likely contributed to these findings.

How do people understand the risk of COVID-19?

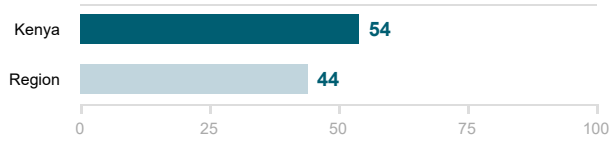
85% believe that COVID-19 will affect many people in their country



33% believe that their personal risk of being infected with COVID-19 is high

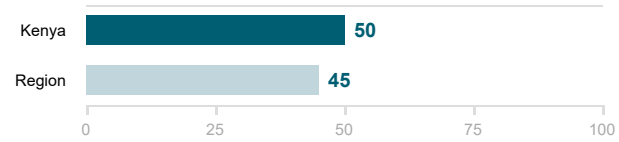


54% believe that their health would be seriously affected by COVID-19

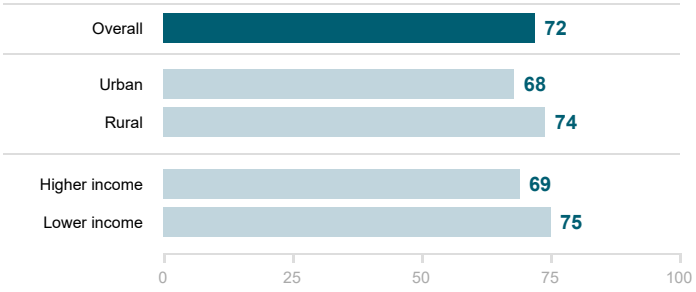


How concerned are people about COVID-19?

50% report COVID-19 as being a top concern



72% are anxious about resuming normal activities



The issues most concerning to people

Percentage of people reporting concern about a particular issue

Access to income/work/unemployment	76%
COVID-19 pandemic	50%
Access to food	44%

Information and Risk Perception

Whom do people trust?

What the data say

As in February 2021, the most trusted institutions for the management of the COVID-19 pandemic were all health-related, including hospitals, the Ministry of Health and the World Health Organization.

- Despite being embroiled in a public corruption scandal about misappropriation of COVID-19 relief funds since February 2021, the president maintained a high level of trust among respondents for his management of the pandemic response (72%).
- Nearly four in five respondents trusted religious institutions' handling of COVID-19, and the same portion reported trusting information disseminated by local religious leaders. This suggests that churches and mosques are valuable partners in promoting PHSM adherence and mitigating misinformation.

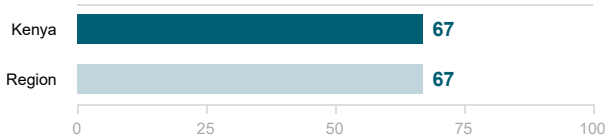
The top three most-trusted sources for information about COVID-19 (health workers, local radio and local religious leaders) did not all align with the sources most frequently consulted by respondents (local television and radio). High trust in health workers and religious leaders suggests an opportunity to use these groups in risk communication and community outreach activities.

- Social media — including WhatsApp (35%), Facebook (35%) and Twitter (30%) — were the least-trusted sources for information about the pandemic; accordingly, few respondents consulted these platforms for information about COVID-19 (16%, 22%, and 7%, respectively). However, respondents aged 18-25 used social media to access information about COVID-19 at much higher rates than those 36 and above (35% vs. 10%), indicating that social media campaigns may be an effective form of communication to targeted populations.

What do people think about their country's institutions?

Satisfaction with the government's response to COVID-19 remained unchanged since February 2021 (68%) and was on par with the Eastern regional average. This was consistent across demographic groups.

67% are satisfied with the government's pandemic response



Top three most trusted institutions and individuals

Percentage of people reporting trust in each person's or institution's approach to the pandemic

Hospitals/health centers	89%
Ministry of Health	86%
World Health Organization (WHO)	82%

Do people believe accurate information?

Accurate information about COVID-19 is widely understood in Kenya; fewer respondents believed narratives promoting the avoidance of health workers (44%) and those who have recently recovered from COVID-19 (45%) than the Eastern regional average (53% and 50%, respectively). A larger share of respondents that believed health care workers should be avoided were from lower-income households (49% vs. 37% from higher-income households) and those with a secondary school degree or less (48% vs. 34% of those with some university schooling or more). Belief in herbal medicines as a cure for COVID-19 was among the least prevalent in the Eastern region.

Most trusted sources of information

Percentage of people reporting trust in information sources about COVID-19

Health center/health workers	85%
Local religious leaders	81%
Local radio	80%

86% understand that infected people may never show symptoms but could still infect others.

84% understand that infected people may not show symptoms for five to 14 days.

28% believe that COVID-19 can be cured with herbal remedies.

44% think they should avoid health care workers because they could get COVID-19 from them.

Vaccine Beliefs and Uptake

Do people want to get the COVID-19 vaccine?

These survey questions aim to describe the available market for COVID-19 vaccine uptake and target populations for information campaigns. We therefore show those reporting being vaccinated or likely to get vaccinated, and those unlikely to get vaccinated. The survey does not seek to validate COVID-19 vaccine coverage.

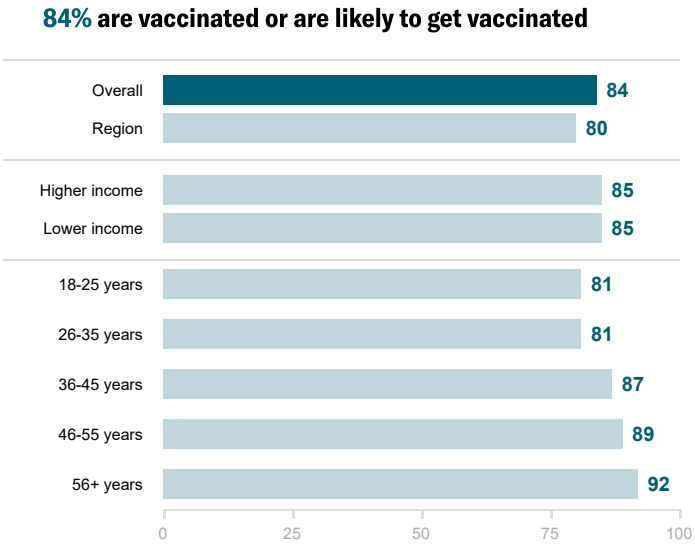
What the data say

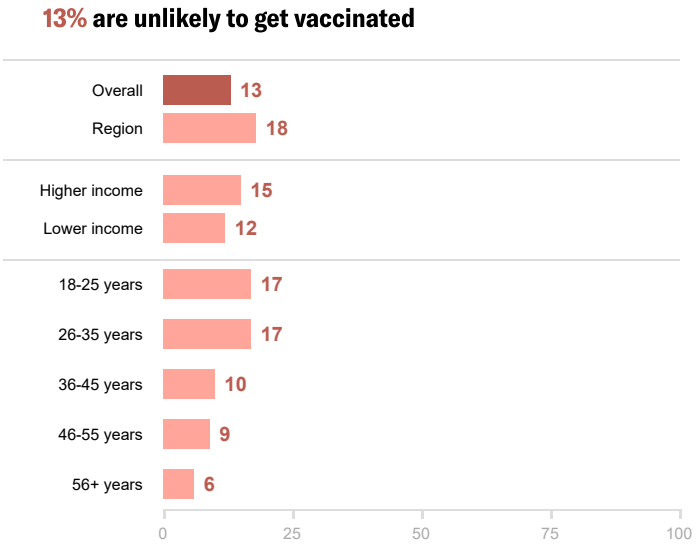
More than four in five respondents reported being vaccinated or planning to get vaccinated for COVID-19, the highest in the Eastern region. This is in stark contrast to levels reported in February 2021, when only two in five expressed interest in receiving the vaccine. Vaccine supply has been inconsistent, and while local manufacturing of COVID-19 vaccines is expected to begin in Q2 of 2022, this will not address the near term supply challenges.

- Confidence in the government was associated with a greater likelihood of vaccination: more respondents who reported high satisfaction in the government's COVID-19 response were vaccinated or likely to get vaccinated (69% vs. 49% of those who were unlikely to get vaccinated).
- Two of the top five reasons cited by respondents unlikely to get vaccinated were negative rumors about the vaccine (19%), and more specifically, the belief that the vaccine is killing people (17%). This is consistent with media reports that suggest beliefs in vaccine misinformation may be driving hesitancy. Two other commonly-reported reasons were low personal risk perception (22%) and lacking enough information to make a decision (17%).The top concerns of those unlikely to receive a COVID-19 vaccine could be addressed in part through continued investment in risk communication and the use of trusted sources to disseminate accurate information.

How many people reported getting or planning to get the COVID-19 vaccine?

Fewer than 5% of respondents reported being unsure about COVID-19 vaccine uptake and are therefore not shown. Percentages reported are among the entire sample.





What do people think about COVID-19 vaccines?

Top information wanted about vaccines

Percentage of people reporting each type of information

How safe is the vaccine?	36%
What are the main side effects and are they painful/serious?	33%
What types of vaccines are there, what are they made of and how do they work?	29%

Top reasons people would not get the vaccine

Among people who were not planning to get vaccinated, their reasons were:

I do not feel I am at risk of catching the virus	22%
Negative rumors about the vaccine	19%
I do not yet know enough about the vaccine to make a decision	17%

Secondary Burdens

Are people skipping or delaying health care?

What the data say

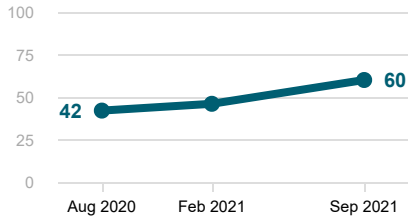
Among respondents who needed care, one-quarter reported missing or delaying health visits in the past six months and two-fifths reported difficulty accessing medicine in the past three months. While the share of respondents that missed a needed health visit decreased since February 2021 (43%), despite ongoing COVID-19 waves, the share of respondents reporting difficulty accessing medication increased (46%).

- While most missed visits were for general/routine care, one in five were for malaria treatment, a disease that affects millions of people and kills more than 10,000 every year in Kenya. Another quarter of missed visits were for fever/chills and/or respiratory problems, symptoms commonly associated with COVID-19. Fever can also be a symptom of malaria or measles, of which there is an active outbreak in some parts of Kenya.
- As in February 2021, cost/affordability remains a top barrier to accessing health care. More respondents who reported losing some or all of their income during the pandemic reported missing a needed health visit than did those who lost no income (28% vs. 10%).

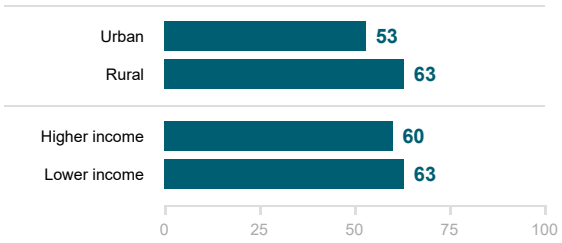
Difficulty getting medicines

A larger share of rural respondents reported difficulty accessing needed medication than urban respondents.

Trend in percentage of households having difficulty getting medicines in the past three months



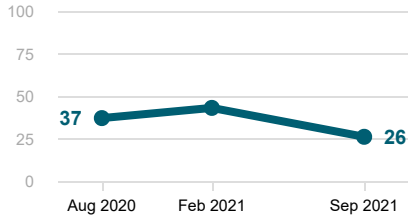
Percentage having difficulty getting medicines by category



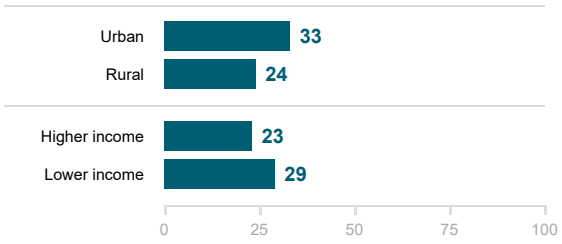
Skipping or delaying health visits

More lower-income respondents reported missing a needed health visit than higher-income respondents; this group also reported cost as their main barrier to access more often (34% vs. 24% among higher-income households).

Trend in percentage of households skipping or delaying health care visits in the past six months



Percentage skipping or delaying health care visits by category



Reasons for skipping or delaying visits
People could choose multiple responses

Cost/affordability	34%
Health facility disruption	21%
Worried about catching COVID-19	12%
Self-isolating with suspected COVID-19	10%
Mobility restrictions/transport challenges	8%

Types of health visits that were skipped or delayed
People could choose multiple responses

General/routine check-up	41%
Diagnostic services/symptoms	24%
Communicable diseases	22%
Reproductive, maternal, newborn, child health	11%
Noncommunicable diseases	11%

Secondary Burdens

Are people experiencing income loss or food insecurity?

What the data say

Nine in 10 respondents reported losing some or all their income since the beginning of the pandemic, unchanged from February 2021. Despite this, very few respondents (4%) reported receiving government assistance.

- Pandemic-related disruptions caused economic contraction and hindered growth in Kenya; tourism — which accounted for 8% of Kenya's overall GDP prior to COVID-19 — was particularly hard-hit by travel restrictions, losing an estimated US$1 billion in revenue in 2020 alone. Climbing debt, increasing taxes and income loss have all forced more people into poverty.
- Almost three in four respondents cited unemployment and income loss as a top concern. Rates of unemployment — particularly among youth — have increased as a result of COVID-19 restrictions; these likely underrepresent of the true burden as many Kenyans are employed informally.

Reported barriers to food access

Percentage of people reporting each barrier

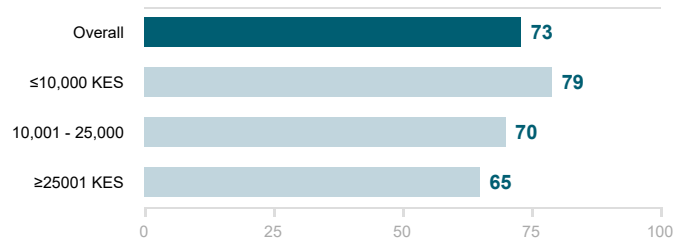
Less income	81%
Higher food prices	84%
Food markets closed	49%
Mobility restrictions	50%
Food market supply shortages	59%

Nearly all respondents in Kenya reported experiencing at least one barrier to food access in the past seven days (94%), a slight increase since February 2021 (89%) and consistent with the onset of the lean season in September. The most commonly-cited barriers to food access were high prices and income loss, both reported by about four in five respondents.

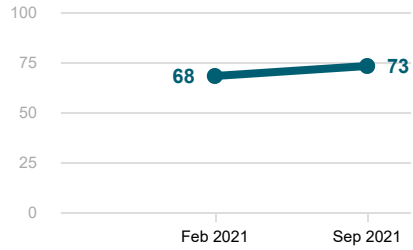
- The share of respondents missing meals increased from 68% in February 2021 to 73% in September, reflecting the deepening hunger crisis brought on by climate change and rising food prices. Pest infestations in some regions — including the worst locust plague seen in Kenya in 70 years— as well as ongoing droughts and below-average rainfall have also affected livestock farming and overall agricultural outputs. More than 2 million people in Kenya are expected to face acute hunger by the end of 2021.

Missing meals

*Percentage of households **missing meals** by category*



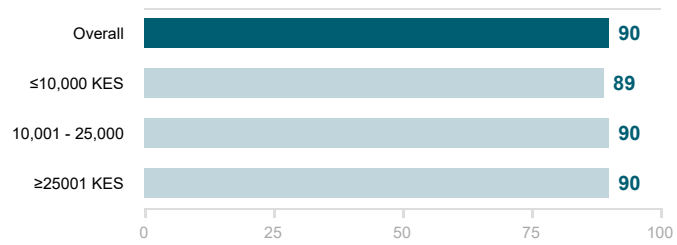
*Percentage of households **missing meals** over time*



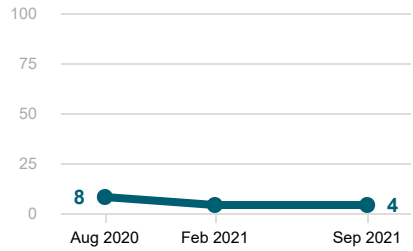
Note: Data on missing meals were not collected in Aug 2020.

Income loss and receiving government assistance

*Percentage of households experiencing **income loss** by category*



*Percentage of households receiving **government assistance** over time*



Appendix

Endnotes

Report notes

Regional comparisons were conducted as per the following categories: Eastern Africa (Ethiopia, Kenya, Uganda, Sudan); Western Africa (Ghana, Nigeria, Liberia, Guinea Conakry, Senegal, Côte d'Ivoire); Northern Africa (Tunisia, Morocco, Egypt); Central Africa (Cameroon, Democratic Republic of Congo); and Southern Africa (Mozambique, South Africa, Zambia, Zimbabwe).

The epidemiology curves on pages one and two of the report shows the 7-day rolling average of new cases from March 2020 to October 2021. Where epidemiology or mobility data are missing, the data are unavailable.

Full survey results are available here and on the PERC online dashboard. *For full details on data sources, methods and limitations, see preventepidemics.org/perc.*

- Ipsos conducted a telephone *survey* of a nationally representative sample of households with access to a landline or cell phone. Results should be interpreted with caution as populations without access to a phone are not represented in the findings. The percentages reported in Ipsos charts may be different from percentages reported in other PERC products and communication of these data. Differences may be reconciled by investigating the denominator and/or weights used.
- Africa Centres for Disease Control and Prevention (Africa CDC) provides *epidemiological* data daily for African Union (AU) Member States. Africa CDC receives case, death and testing data from each AU Member State. Because not all AU Member States report daily, numbers could be delayed, especially for testing data which are more commonly reported late, or in periodic batches (e.g., weekly).
- Other data are drawn from publicly available sources.

Findings reflect the latest available information from listed sources at the time of analysis, and may not reflect more recent developments or data from other sources. Data vary in completeness, representativeness, and timeliness.

Country notes

The survey sampled from Kenya consisted of 1,356 adults (419 urban, 937 rural), collected between 20 and 29 Sep 2021.

Income classifications were based on existing data on local income distributions, which were used to create three income bands, defined as:

- Lower-income: Monthly household income 10,000 KES or less
- Middle income: Monthly household income 10,001 KES - 25,000 KES
- Higher-income: Monthly household income 25,001 KES and above